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Work as therapy is increasingly suggested as a means of helping the patient to develop and maintain stronger bonds with the community. The goal of a 44-month project, of which the initial 20-month period is reported, is to develop manpower programing knowledge to meet the vocational development needs of mental patients and to evaluate the manpower potential of this labor pool. The project provided vocational counselors to participate on several of Fort Logan's eight psychiatric teams which served 800 patients, of whom only a small percentage were under 24-hour care. During this initial period, 479 patients were served in some way by the project and 236 were placed on training or on jobs. It was concluded that a reasonable proportion of persons treated for major mental illnesses can return to work, some in spite of immense residual emotional handicaps, and it was estimated that 90 percent could benefit from vocational counseling and rehabilitation services. Integration of the vocational counselor on the therapeutic team increases the counselor's sensitivity to the patient's therapeutic needs and the hospital's sensitivity to his vocational needs. Personal and honest communication with employers is recommended. (JK)

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MDTA EXPERIMENTAL AND DEMONSTRATION FINDINGS

MENTAL HEALTH AND MANPOWER EMPLOYMENT ADJUSTMENT FOR PSYCHIATRIC PATIENTS

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MDTA EXPERIMENTAL AND DEMONSTRATION FINDINGS

MENTAL HEALTH AND MANPOWER EMPLOYMENT ADJUSTMENT FOR PSYCHIATRIC PATIENTS

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PREFACE

This monograph is an abstract of the results of the first 20 months of an experimental and demonstration project in mental health and manpower. Conducted jointly by Colorado State University, Fort Collins, Colorado, and the Fort Logan Mental Health Center, Denver, Colorado, the project is funded under the Manpower Development and Training Act by the Manpower Administration, U. S. Department of Labor, to continue until June 1968.

This abstract, prepared by the project staff, summarizes the objectives and methods of the project in the 20-month period, and presents the conclusions and recommendations derived.

Studies have illustrated the possibilities and need for integrating related health, rehabilitation, and labor resources into a comprehensive program. The Colorado Department of Vocational Rehabilitation (DVR) is allied with the Labor Department in an attempt to extend services to psychiatric patients and to attempt new methods in areas where vocational rehabilitation has not always been of sufficient aid. DVR staff members have served as consultants and have been highly supportive. Other supporting agencies include the Bureau of Apprenticeship and Training (for on-the-job placements), the Division of Vocational Education (institutional training program), and the Colorado Employment Service (placement). The cooperative relationship between these agencies is of considerable assistance in the development of effective job placements.

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MENTAL HEALTH AND MANPOWER

EMPLOYMENT ADJUSTMENT FOR PSYCHIATRIC PATIENTS

There are many reasons why one should be concerned with the employability of the psychiatrically disabled. Aside from the misery suffered by such people and those around them, the impact of mental illness upon the economy is enormous. The loss to the nation of the potential earnings of all first admissions in any one year to State mental hospitals alone (not including those patients in private care, etc.) is in excess of two billion dollars.[1] The development of employment capabilities for these patients becomes of critical concern in a nation which values both social and economic productivity.

Partly in recognition of these needs, many State hospitals have begun to explore more active forms of treatment and to reevaluate their discharge policies. With the discovery that the majority of patients can be treated and released quickly, attention has shifted from indefinite hospitalization and long term custodial care to a concern with the restoration of patients to productive roles in society.

One of the few factors which has been found to be related positively to community adjustment of the returned mental patient is work adjustment. As mental hospitals continue to develop their treatment programs with all of the implications of increased community contact, open doors, voluntary admissions, etc., there is an increased need for attention to ways of promoting community functioning, and adjustment in both the personal and work environment has become a primary concern.

Research indicates that none of the traditional therapeutic approaches--individual therapy, group therapy or even no therapy--has any reliable effect on the ability of patients to perform successfully in the community; however, work-as-therapy is increasingly suggested as a means of helping the patient to develop and maintain stronger bonds with the reality-oriented community.

Program Description

Project Goals -- The Mental Health and Manpower Project was initiated in October 1964, with the stated general goal of "developing

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1 Gorman, M. "Mental Illness: Legislative and Economic Considerations." Paper read at the Joint Session of the American Orthopsychiatric Association and the Mental Health Association of the American Public Health Association, November 1961.

manpower programming knowledge for meeting the vocational development needs of mental patients and of evaluating the manpower potential of this labor pool." The project was administered cooperatively by Colorado State University and the Fort Logan Mental Health Center and had as its specific aim the re-training, upgrading, and placement of mental patients, both out-patient and resident.

A key intention of the project was to integrate this practical goal with a meaningful philosophic base; therefore, the efforts of project personnel were focused upon the following special problem areas:

(1) the development of a conceptual framework within which to understand the vocational problems of mental patients;

(2) the development of a counselor role which could meet these problems most effectively;

(3) the development of methods of overcoming employer bias in order to place former patients in jobs best suited to their needs and abilities;

(4) the determination of the effectiveness of on-the-job and institutional training programs in returning mental patients to economically productive work roles.

Of these major project goals, the first two were the most critical in that they heavily influenced development and usage of the available treatment and rehabilitation resources.

Project Procedures -- The Fort Logan Mental Health Center provided the primary headquarters for the project. Fort Logan is a new State hospital organizationally decentralized into eight psychiatric teams, each of which serves specific sections of the Denver metropolitan area. There is an additional alcoholic unit which serves the entire area. There are no locked doors at the hospital, and there is a heavy emphasis on day treatment. Only a small percentage of the approximately 800 patients are under 24-hour care.

The method of treatment involves a variety of group process activities. All staff members, from psychiatrist to psychiatric technician, as well as the patients themselves, are considered part of the treatment team. Each, including the patient, has the responsibility to participate therapeutically regardless of traditional role definitions.

The methods employed with project patients varied widely according to the needs of the individual as these were determined by the Fort Logan and project staff and by cooperating State and Federal agencies. Insofar as possible, the project was integrated into the therapeutic program of the hospital and, therefore, the patient first came into contact with

the project through general information communicated by the hospital staff.

The patient's first real contact with the project came with his assignment to a psychiatric team. Vocational Counselors from the project participated as full or partial members of several teams. Depending upon their team assignments, they conducted screening interviews with patients, assisted with testing, and participated in general staff meetings. Thus, the counselor had the opportunity to observe and to interact with each patient during the treatment period and before his referral for project services.

Once the referral was made, the project staff in consultation with the psychiatric team reviewed the patient's case records, conducted further interviews, and applied further vocational tests as needed. The results of the project staff's clinical and test evaluation were combined with the information supplied by the psychiatric team to determine the final plan of assistance. The patient either was helped to find a job directly or was provided with an appropriate training experience.

In the event of training, the patient was placed in a situation where he could acquire new job skills complementary to his individual employment needs. In addition to the work therapy program, there were three general categories of training:

(1) placement in an on-going training program in public or private institutions;

(2) on-the-job training programs in the community and/or in the hospital;

(3) placement in a regular on-going MDTA training project established in the Colorado area.

After the training experience, the patient was placed on a job with the cooperative efforts of the employment services. Supportive counseling was given throughout all stages of selection, training, and placement. In addition, project staff met with employers on an as-needed basis in order to review the patient's job progress. Wherever possible, evaluation follow-up was performed with both patients and employers. This follow-up information enabled the project staff to determine the success of their efforts and to modify their procedures throughout the project.

Research Findings: Factors Related to Success and Failure in the Vocational Adjustment of Mental Patients

The Mental Health and Manpower project provided a novel vocational rehabilitation service in a mental hospital setting and successfully

returned a considerable number of patients to the world of work. The project also included a research plan that was aimed at finding out more about mental patients and why they succeed or fail after they are placed. This general research plan was based on the recent model of work adjustment published by the Industrial Relations Center of the University of Minnesota.[2] Earlier models were almost entirely concerned with matching the man to the job, and with whether the man had the abilities necessary to do the work. The new approach points out that work adjustment is a two-way street. For full adjustment the man must not only meet the requirements of the job, but the working conditions of the job must meet the man's work needs. For adequate work adjustment, the man must not only be satisfactory to the employer but must also be satisfied with the job.

A number of research instruments were either constructed for the project or used with the permission of the Industrial Relations Center or the Fort Logan Record System.[3] These forms were designed to measure the satisfactoriness and satisfaction of the worker on the job, and such predictive variables as the patients's abilities and needs. In addition, considerable demographic data (e.g., age, sex, education, etc.) was obtained for each patient. In all, a sample of 178 patients were fully tested. These patients represent only a part of those formally referred to the project, and all were either placed in on-the-job training programs, directly in job positions, or in MDTA classroom (institutional) training between November 1, 1964, and January 31, 1966.

Initially, to allow early analysis of the data, a patient was classified as a success if he had completed a minimum of three weeks in the placement and was still working at the time the study was completed. Later, an independent study was done using a six month rather than a six week criterion. While there were a considerable number of late failures, the relationships were essentially the same. Table I shows the success rate for the various types of placement offered.

The success rate for on-the-job training was significantly lower than that for institutional training or direct placement. The reasons for this high rate of failure are not clear. Since the termination of the project, we have found that warning counselors about this problem led to a sharply reduced number of OJT placements; however, when this information was communicated, the success rate was increased to about the same level as that for other types of placement even though the actual number of referrals to OJT remained low.

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2 Dawis, R. V., England, G. W., & Lofquist, L. H. A theory of work adjustment. Minnesota studies in vocational rehabilitation: XV. Minneapolis: Industrial Relations Center, 1964.

3 Information on diagnostic classification, and descriptive characteristics of mental patients was provided by the Fort Logan Record System, supported in part by Public Health Service Grant No. 5-R11 Mh 00931-05.

TABLE I

Type of Placement and Success in Rehabilitation from Psychiatric and Alcoholic Division

	On the Job Training	Institutional	Direct Placement	
			Self Obtained	Project Obtained
Alcoholic				
Fail within 3 wks	7	2	2	6
Fail after 3 wks	8	6	6	6
Success	6	6	34	14
% Success	29%	43%	81%	54%
Psychiatric				
Fail within 3 wks	10	0	1	8
Fail after 3 wks	6	2	0	4
Success	5	23	5	12
% Success	24%	92%	83%	50%
Total % Successful	26%	74%	81%	52%

The highest success rate occurred in direct job placement, where the patient, after referral to the project and talking with the vocational counselor and perhaps the placement counselor, sought and found his own position. These patients were probably the most capable and the most independent of the referrals, and their higher success rate might be expected.

Almost all of the psychiatric patients succeeded in institutional training while more than half of the alcoholic patients failed. Again, we are not sure of the reasons, but suspect that patients who show behavior problems in the classroom may be tolerated and encouraged to remain, while alcoholics going back to drinking do not come back to class or are expelled.

Among the demographic characteristics studies, sex, age, and cultural group (Spanish, Negro, Caucasian, etc.) were not related to success or failure. There was a hint that patients in certain religious groups that had a high level of family and interfamily cohesiveness tended to succeed more often, although the number of patients in this group was very low. Patients who had a history of breakdown in marital relationship (separated or divorced) had a higher rate of failure (50 per cent) than single or married patients (32 per cent).

The patients as a group showed very inadequate employment patterns before entering Fort Logan. In one sample, none had been employed in the same job for more than five years. By contrast, about half of the usual sample of unskilled blue collar workers had held the same job for over five years. However, neither (1) the specific occupation held prior to admission, nor (2) the number of jobs held in the past two years, nor (3) whether the patient had been on welfare was related to rehabilitation success.

Severity of emotional disturbance might be expected to be related to rehabilitation success. As has been found in other studies, diagnostic classification was related to neither the severity factor nor to rehabilitation success. Nonvoluntary admissions did tend to show low success rates. Patients assigned on admission to the outpatient department (usually given one evening of treatment per week) have a very high success rate (90 per cent), compared to day care (66 per cent), Halfway House (54 per cent), and 24-hour care (55 per cent). One of the more interesting findings was the significant relationship between length of time in the hospital and rehabilitation success. Successful patients had spent a greater length of time on hospital rolls (mean = 233.9 days) than did those patients who were not successful (mean = 143.5 days).

As part of counseling the counselors filled in a rating form, the Ability Rating Form, evaluating the abilities of their patients. The ratings in regard to intelligence and health were not useful for differentiating successes and failures. The ratings done for Stress Tolerance and Interpersonal Relations, although not different for successes and failures, placed alcoholics noticeably higher than psychiatric patients. Because the form did not seem to be useful a new form, the Patient-Placement Congruence Form, was introduced. This form required the counselor to rate the "fit" between the patient and his proposed job. The final rating on this form simply asked the counselor to rate, in general, chances of success on the job. In this case, the counselor ratings successfully differentiated between psychiatric patients who maintained work adjustment and those who failed. It is noteworthy that there was no significant difference between successful and failing alcoholics on this rating.

In order to measure a patient's "social impact" upon others, the Evaluative Differential was utilized. The test uses a semantic differential format and the counselor rates the patient on 26 adjective pairs. The Evaluative Differential scores for both alcoholic and psychiatric patients did not differ significantly between the success and failure groups, although means for psychiatric patients showed differences in the predicted direction. However, when these results were tabulated separately for the different counselors, it was found that for certain staff members, there were highly significant differences between the success and failure groups. While this finding could be attributed to differential ability of the counselors to make relevant ratings, it might be related to degree of involvement in the therapeutic process for the patient and/or orientations and attitudes of the staff of the treatment unit on which the counselor worked.

The Supervisor Report Form, a rating by the supervisor of the patients satisfactoriness on the job, was filled out by the employers. Scores correlated .34 with the Evaluative Differential after three weeks on the job and .33 after three months. The correlations are both positive, both of about the same order, and both of about the level that would be expected to exist if social impact were one of the underlying variables contributing to satisfactoriness as an employee.

Recommendations

The program terminated June 10, 1966. In July, having reviewed the results of the program, it was found that approximately 236 patients had been placed in training or in jobs. The program also served in some way a total of 479 patients. These statistics do not tell the whole story but do show that Mental Health and Manpower was able to provide a spectrum of traditional and experimental services to a large mental patient population. The evaluation of program problems and successes in dealing with this population has led to a set of statements which may be useful in fashioning similar programs. These are presented below in four major areas: vocational implications, administrative programming, job development, and counseling.

Vocational Implications

It is not useful to apply traditional counseling and placement approaches to the mental patient. Evidence is clear that these individuals need more careful and detailed counseling and follow-up than has been given them by the application of methods developed for dealing with the physically disabled.

A reasonable proportion of persons treated for major mental illnesses can return to the labor market, some in spite of immense residual emotional handicaps. One important factor in returning greater numbers of patients to full vocational functioning is the use

of proper vocational planning and supportive follow-up.

Previous estimates have stated that from 10 to 15 per cent of mental patients can profit from special vocational services. The Mental Health and Manpower project served 75 per cent of the adult psychiatric patients released from the Fort Logan Mental Health Center. It is estimated that 90 per cent of mental patients could benefit from some sort of vocational counseling and rehabilitation services.

Administrative Programming

It is clear that the mental hospital is oriented primarily to personal therapy and does not always take reality factors into sufficient consideration. This project has demonstrated that a patient's vocational needs are an important dimension of the therapeutic process, but that in order to make an impact the vocational counselor must prove to other mental health professionals that work adjustment relates significantly to personal-emotional improvement and to more successful community functioning.

Vocational counselors, in their turn, sometimes tend to see only one side of the patient. It has become apparent that the social-emotional aspects of an individual are even more deeply and delicately intertwined with vocational success than previously had been supposed. The communication provided by the project - hospital integration made it very clear that each had something to learn from the other before they could work together in a maximally effective program.

Job Development

Jobs are definitely available for former patients. Employers, particularly small employers, are willing to work with patients and perhaps even give them more attention than regular employees. While patients often report considerable employer bias after interviewing for employment, patient anxiety is often only an expression of the fear generated within a person who once again is confronted with a highly valued area of life in which he has failed repeatedly in the past.

Patients can usually handle some kind of job. Their failure rate is probably higher than that of the typical employee, but there is also evidence that careful counseling and job development with adequate follow-up services enables the patient to have a reasonable chance of success in regular employment.

It is helpful in developing placements to invite employers into the hospital to view the facilities. Personal contact with employers concerning strengths and weaknesses of mental patients clearly wins positive responses. An honest approach can do much to aid in the development of placements.

In the previous section, it was noted that institutional training and direct placement were relatively more successful among the patients served by this project. This finding appears to be inconsistent with recent knowledge which indicates a higher job placement rate for OJT graduates over institutional graduates. Further work is needed to establish cause and effect relationships. It must be remembered, however, that failure is relative to the type of placement whether direct, OJT, or institutional.

Counseling

An important finding has been that the typical rehabilitation counselor is too concerned with "placement" and the mental hospital is too concerned with "therapy." Integration of the vocational counselors on the Fort Logan therapeutic teams has proven to be immensely valuable. Placements are now made with more attention being paid to the patient's therapeutic needs while the hospital in its turn is becoming sensitized to the vocational needs of the patient. In the past, the patient has had to go from a completely therapeutic situation, emphasizing openness, feeling, and relationships, to a radically different setting, emphasizing reality and decision making.

This project has demonstrated that the counselor can be a valuable part of the therapeutic process and that he has greater potential for returning the patient to an effective role in society when he (1) is involved with the patient early in the hospital experience; (2) understands and is concerned with the therapeutic aims of the hospital; and, (3) interprets vocational needs to the therapy team and encourages concern with vocational goals as well as personal goals.

The following specific recommendations to counselors should, if carried out, facilitate rehabilitation efforts:

(1) There is a need to help patients establish valid goals. Many patients have unrealistically high expectations for employment. It takes skillful counseling to help the emotionally disturbed find meaningful vocational goals at an employment level reasonable for their abilities and educations.

(2) Hurried counseling, followed by rapid placement, almost invariably leads to failure on the job. This is particularly true where placement is determined by availability of a job rather than the needs of the patient.

(3) In judging the patient's potential for success, the counselor must evaluate the patient from the point of view of the employer and the job. Viewing the patient only in terms of his own abilities does

not work. Along these lines, the traditionally-encouraged insight and acceptance of the counselor may actually interfere with his ability to predict the patient's future success or to evaluate his readiness for placement.

(4) Early placement may be associated with failure. One should consider carefully not only the patient's clinical progress, but the impact of his present behavior on his environment before determining readiness for placement. There is evidence that the rehabilitation process is accompanied by a great deal of stress. The patient who appears ready for rehabilitation may regress and his emotional disturbance may recur if the treatment period has been too short.

(5) Patients who have background characteristics suggestive of extensive breakdowns in family relationships, particularly where this is manifest in divorce and separation, may have a higher rate of failure upon their return to work. Follow-up supportive counseling may be highly advisable.

(6) Success rates for different types of placement differ. The rate for OJT was low in our project. It is apparent that extensive use of OJT as a placement device should be carefully monitored. Institutional training had a high success rate, but we have not, as yet, established that later job success is equally high. If such is indeed the fact, there may be great promise in this type of training when it is used to provide an adjustment period between hospitalization and full employment.

In direct placement, the patient who finds his own job succeeds more frequently. While this is undoubtedly the result of a selection factor, with patients showing this degree of independence being more ready for and capable of readjustment, it also may be taken to indicate that patients who do not have this capacity are somewhat lacking in placement readiness and should be placed with caution and carefully evaluated over a period of time.

Conclusions

By integrating the vocational counselor with the therapeutic team, the Mental Health and Manpower project has brought greater recognition of vocational problems of psychiatric disability into treatment programming for mental patients. This project has demonstrated that such integration can take place and has provided considerable evidence that this type of coordinated effort provides for greater effectiveness than is obtained when hospital, rehabilitation, and other treatment, employment, and training agencies attempt to segment the problems of the patient. This traditional segmentation is improper and unrealistic.

In the case of the physically disabled, both the causes of the disability and the behavioral manifestations of that disability may be, and usually are, multiple. The person with a missing arm and the person with cerebral palsy have strikingly different characteristics. They have in common only the fact of disability. We are unlikely to spend very much time in contemplating the buzz saw that may have caused the disability--we proceed with a course of treatment designed to rectify the impairment or minimize its consequences to the adjustive capacity of the individual.

In the case of psychiatric disability, we have tended to be concerned with causes and psychodynamics rather than with the identification of the characteristics of the disability, and with rectifying or minimizing their consequences. It is not that psychiatric disabilities do not have causes. The patient may have come from an impoverished environment (fifty to eighty per cent are unskilled, blue collar) where he failed to learn appropriate behaviors, learned all the "wrong" things, or both. He may have a long history of high level stress, or he may have had, in the classical dynamic tradition, a traumatic and disabling experience. However, knowledge of causes is important only insofar as this knowledge can assist in the planning of corrective measures.

Traditional diagnostic systems do not help us either in determining causes, in predicting success, or in planning corrective measures. We do know, however, that the person classified as psychiatrically disabled does not have the behavioral repertoire that will permit him to function effectively in the environment. In the rehabilitation (or habilitation) of these individuals, we have to be able to specify precisely the nature of his disabilities--the things he is unable to do--and either increase his capability or place him in an environment for which he has the behaviors requisite to adjustment.

The Future Goals of Mental Health and Manpower

The central goal of the continuing MHM project is evaluation in further depth of the labor market implications of America's mentally ill and the role that effective rehabilitation counseling in the new mental hospital plays in aiding patients to return to work. In effect, two basic questions are being asked:

(1) What is the function and role of vocational counseling in the hospital and mental health center of tomorrow?

(2) What are the implications for the nation's "manpower pool" of mental patients for the labor market and for counselors who will help former patients find jobs?

The basic method of the ongoing project remains similar to that of the first phase. Simply stated, this project represents: (1) an integration of vocational rehabilitation services into the therapeutic

framework of a modern mental hospital; (2) experimentation with more prevocational and training alternatives than is ordinarily possible in rehabilitation; (3) rigorous experimental study of the effect of extensive follow-up and counseling services after the patient leaves the hospital; and (4) research and evaluative procedures to determine the relevance and effectiveness of these several approaches.

Speaking more specifically, Mental Health and Manpower has established the following aims for the continuation phase of 24 months:

(1) Provision of services to a minimum of 500 psychiatric patients with a placement goal of 300.

(2) Research and evaluation efforts of the project will be expanded. The addition of an economist or other qualified individual to the staff will make possible more careful analysis of the employment implications of this manpower pool. Publication of reports and the development of a general manpower monograph describing the project operation is a major goal of the evaluation staff. The primary research effort is aimed at contributing to the knowledge of vocational rehabilitation by (a) a controlled study of the effect of group and individual supportive counseling during the post hospitalization period, (b) developing more thorough and complete studies of factors related to the success and failure of vocational rehabilitation in mental patients than have been available in the past, (c) evaluating the relationship of type of placement or training on vocational rehabilitation success, and (d) studying the relationship between the counselor's evaluation of patient abilities, factors, such as the patient's social isolation, and rehabilitation success. In addition, a special effort is being made to test the validity of a theory of work adjustment proposed by the University of Minnesota and its applicability to the vocational rehabilitation of mental patients.

(3) Special attention will be given to the role of the vocational rehabilitation counselor on the therapeutic team. Fort Logan Mental Health Center is a prototype for the mental hospital of the future, and provides a unique opportunity for studying the integration of the vocational rehabilitation process into the mental health milieu of the therapeutic community. The situation offers an unusual opportunity to shape the emerging and expanding role of rehabilitation counseling of the mental patient. For example, by making the counselor a part of the therapeutic team, it may be possible to bring the concepts of rehabilitation into the therapeutic process in such a way that the whole team becomes concerned with the total rehabilitation process and not simply the emotional problems of the patient.

(4) Development of a community work therapy program with Denver industries in which mental patients are placed in real work situations for part of the therapeutic day at the hospital. An employer-sponsored work therapy program, unique in the history of vocational rehabilitation, is now being developed.

(5) Efforts will be expanded in the area of training. In-service training workshops are planned for employment service personnel, rehabilitation counselors, school counselors, social workers and similar groups. The project has hopes of establishing a national conference on rehabilitation of the mental patient.

(6) The project will work with State and local agencies in a training and consultative function. In the past, the project has received excellent cooperation and support from these agencies. It is now time to "feed-back" findings and to aid these agencies in planning future work with the mentally ill.

The project is marked by demonstration efforts coupled with controlled experimentation. Various techniques will be used to determine which are more effective in aiding the mental patient to find himself in the world of work. A final report will answer a number of specific questions about the effects of follow-up supportive counseling on rehabilitation success and hopefully will provide other information helpful to a wide variety of agencies concerned with the problems of the vocational adjustment of the mental patient.

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